Michigan Department of Natural Resources
Forest, Mineral and Fire Management

TIMBER SALE
VERIFICATION OF WORKER'S DISABILITY COMPENSATION ACT COMPLIANCE

As required by Act 317, P.A. 1969 (Worker's Compensation) and Part 525 of Act 451 of 1994, as amended.

FOR DEPARTMENT USE ONLY	
Sale or Permit No	
Year:	Type:
Forest Area:	

VERIFICATION OF WORKER'S DISABILITY COMPENSATION ACT COMPLIANCE

- **This verification must be completed and submitted within 21 days of contract award and prior to the issuance of the timber sale contract.**
- **In addition, if boxes 2B or 2C are checked, then Notice of Exclusion or Certificate of Insurance must be submitted within 21 days of the contract award and prior to the issuance of the timber sale contract.**
- **All Information must be typed or printed except for written signatures.**

Please Check Appropriate Categories:

1. My business is organized as (you **must** check one of the boxes below):
   - A. ☐ Sole Proprietorship (individual)
   - B. ☐ Partnership
   - C. ☐ Corporation

2. You **must** check one of the boxes below:
   - A. ☐ I certify that my business is a sole proprietorship and it has no employees but the sole proprietor. I am not subject to the Worker's Compensation Laws.
   - B. ☐ I certify that my business has satisfied its obligation to the Worker's Compensation Act through the use of an approved Notice of Exclusion (BWC-337, Rev. 5/96). I will provide a copy of the Notice of Exclusion within 21 days of the contract award. (For questions or a copy of the BWC-337, please call the Worker's Compensation Bureau at 517-322-1195).
   - C. ☐ I certify that my business has a Worker's Compensation Policy. I will provide an original Certificate of Insurance within 21 days of the contract award.

3. If you have checked item 2(A) or 2(B), you **must** indicate the number of **both** full and part time employees other than yourself including family members and active partners (if none, you must enter "0").

_____ Full Time Employees _____ Part Time Employees

Name of Business		Federal ID (or) Social Security No.
Address		Telephone No. ( )
City	State	Zip + 4

I hereby certify that the above information is true and correct. I agree to notify the DNR of any changes that occur in factors affecting my coverage during any of my present and future operations.

_____
Signature of Owner or Authorized Representative

_____ _____
Title Date